Kathleen Babineaux Blanco
Governor

LOUISIANA WORKS
DEPARTMENT OF LABOR

John Warner Smith
Secretary

CONFIDENTIAL

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE WORKER'S COMPENSATION ACT.

LOUISIANA OFFICE OF WORKERS' COMPENSATION
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9040
PHONE (225) 342-5658
FAX (225) 342-7578

SERVICE COMPANY APPLICATION

1. Name of Applicant _____
   _____
2. Applicant status Corporation ( ), Partnership ( ), Individual ( )
3. Address of Home Office _____
   _____
4. Address of Louisiana Office _____
   _____
5. Names and Addresses of Owners, Partners or Corporate Officers
   _____
   _____
   _____
6. Name and Address of Resident Claim Agent
   _____
   _____
   _____
7. Include summary data and resumes of your personnel in accordance with Sec. 1715 (c).

Office of Workers' Compensation

1001 North 23rd Street ¢ Post Office Box 94040 ¢ Baton Rouge, LA 70804-9040
PHONE 225-342-7561 ¢ FAX 225-342-5665 ¢ www.LAWORKS.net

We certify that the information submitted with this application is true and correct to the best of our knowledge. Further, we agree to update any change in our personnel or report any data material to this application to this office as the need may arise.

_____
(applicant)

By _____
(official and title)

State of _____

Parish or County of _____

Subscribed and sworn to me by _____

on this _____ day of _____ 20____

(SEAL)

_____
(Notary Public)

My Commission Expires:

_____